VERMONT
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2086

Agency of Human Services

Dental Services Prior Authorization Request Form

(Effective 01/01/2008)

(Please Print or Type)

1. Patient Information:

Patient Name: _____

Date of Birth: _____ Age: _____

Patient Medicaid I.D. Number: _____

2. Treatment Request:

Procedure Code(s): _____

Procedure Code Description: _____

Reason for Request: _____

_____

_____

_____

_____

Treatment Rendered? ☐ No. ☐ Yes. If yes, Date of Service: _____

3. Attachments:

☐ None.

☐ ADA Claim Form.

☐ Radiograph(s). Specify type: _____

☐ Periodontal Charting.

☐ Other. Specify: _____

(Continue on back)

4. Provider Information:

Provider Name/Practice Name: _____

Medicaid Individual and Group Provider Number(s): _____

Date Submitted: _____

I certify that my examination of this patient and his/her diagnostic materials was conducted in conformance with the Laws and Regulations of The Board of Dental Examiners of the Vermont Secretary of State Office of Professional Regulation, and that my diagnosis of his/her condition as set forth herein is accurate to the best of my professional judgement.

Provider Signature: _____

Submit this PA request and all supporting documentation to:

Department of Vermont Health Access
Clinical Unit
312 Hurricane Lane, Suite 201
Williston, VT 05495
Fax: 802-879-5963